Clallam County Sheriff's Office
WASPC Accredited Agency

Brian King
Sheriff

Unexpected Fatality Review Committee Report

2025 Unexpected Fatality Incident 25-05523

Report to the Legislature

Pursuant to RCW 70.48.510

Date of Publication: 10/23/2025

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Legislative Directive

Per ESSB 5119 (2021) / RCW 70.48.510

A city or county department of corrections or chief law enforcement officer responsible for the operation of a jail must conduct an unexpected fatality review when a person confined in the jail dies unexpectedly.

The city or county department of corrections or chief law enforcement officer must issue a report on the results of the review within 120 days of the fatality, unless an extension has been granted by the chief executive, or if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the Legislature.

The Department of Health must create a public website where reports must be posted and maintained. Reports are subject to public disclosure and confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with applicable state and federal laws. No provision of this act may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

Unexpected fatality review is defined as a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the care and custody of the city or county department of corrections or chief local enforcement officer, regardless of where the death occurred. A review must include an analysis of the root cause or causes of the unexpected fatality, and an associated corrective action plan for the jail to address identified root causes and recommendations made by the unexpected fatality review team.

Disclosure of Information
RCW 70.48.510

(1)(d) Upon conclusion of an unexpected fatality review required pursuant to this section, the city or county department of corrections or chief law enforcement officer shall, within 120 days following the fatality, issue a report on the results of the review, unless an extension has been granted by the chief executive or, if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the legislature, and the department of health shall create a public website where all unexpected fatality review reports required under this section must be posted and maintained. An unexpected fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the department of health public website, except that confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with the requirements of applicable state and federal laws.

(4) No provision of this section may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

UFR Committee Meeting Dates and Location

Meeting date: 09/29/2025

Location: Virtual via Microsoft Teams

Committee Members

Clallam County Public Health

- Allison Berry, MD, MPH – Clallam County Health Officer

Clallam County Clinical Services

- Madison Gallentine, RN – Clallam Clinic Director
- Pamela Cunningham, RN – Jail Nurse

Clallam County Sheriff's Office

- Alicia Newhouse – Corrections Sergeant
- Don Wenzl – Chief Corrections Deputy (Facilitator)

Inmate Information

The decedent was a 55-year-old male with a history of tobacco and methamphetamine abuse. He was booked into the Clallam County Correction Facility in Port Angeles by a Washington State Patrol officer on May 29, 2025, at 1500 hours.
His charge was a Department of Corrections Secretary's Warrant with an anticipated release date of June 11, 2025.
The decedent was processed into CCCF per standard practice. A medical screening was conducted by a deputy at booking and the decedent self-reported no medical issues.
On May 30, 2025, at 1102 hours, he declined to see the jail nurse for the standard initial medical assessment. This assessment is conducted on each new arrest within 24 hours of booking. At 1441 hours, the same day, the jail nurse was able to complete the initial assessment. He was noted as ambulatory, calm, and cooperative. He made good eye contact with the nurse and had unlabored respirations. The nurse was able to conduct a urinalysis test which was positive for amphetamine/methamphetamine.

Incident Overview

On June 1, 2025, after reporting shortness of breath to jail staff, and evaluation by the Port Angeles Fire Department, it was determined that further assessment at OMC was needed, and he was transported via aid car.

At the hospital, the decedent was examined by medical staff and underwent diagnostic testing, including laboratory tests for Influenza A and B, RSV, COVID-19, and NAAT, as well as a chest X-ray. The decedent was advised to discuss the imaging findings and any related recommendations with the ordering provider. Vital signs recorded at the time included a blood pressure of 104/75 mmHg, temperature of 98.2°F, pulse of 95 beats per minute, respirations of 17 per minute, and oxygen saturation of 98%.

Following evaluation, the decedent was diagnosed with an unspecified cough and shortness of breath. He was prescribed albuterol, Tessalon, methylprednisolone, and Atrovent. Discharge materials included educational literature regarding *Chronic Cough with Uncertain Cause (Adult)*, *Acute Bronchitis*, and *Diagnosing COPD*.

The decedent was released back to the custody of jail staff following completion of medical evaluation and treatment recommendations.

On June 3, 2025, at approximately 1919 hours, corrections staff at the Clallam County Corrections Facility responded to a medical emergency involving the decedent in A Tank. The decedent was observed seated on the floor near the entry door, breathing heavily and appearing in distress. Jail staff initiated a medical

response, provided the decedent with his inhaler, and retrieved medical equipment to assess vital signs. Despite these efforts, the decedent's condition did not improve, and he reported feeling dizzy, overheated, and unable to breathe. Custody staff notified supervisory personnel and requested emergency medical services. Upon arrival of medics and EMTs from Clallam County Fire District and Olympic Ambulance, the decedent was prepared for transport. While being moved from the facility, the decedent became unresponsive, and EMS-personnel initiated life-saving measures.

The decedent was transported by ambulance to Olympic Medical Center, where resuscitative efforts continued in the emergency department. Despite these measures, the decedent was pronounced deceased at approximately 2030 hours.

Following the pronouncement, custody staff remained with the decedent until investigative personnel from the Clallam County Sheriff's Office, OPNET, and the coroner arrived and assumed responsibility for the body and associated evidence. A Tank was secured as a crime scene, and the two remaining inmates housed in that area were relocated, searched, and scanned for contraband, with negative results.

Sequim Police Department Investigation

At the request of the Clallam County Sheriff's Office, the Sequim Police Department initiated an independent investigation into the in-custody death of the decedent to determine whether contraband or controlled substances contributed to the incident.

Preliminary information indicated that the decedent, a 55-year-old male inmate, had experienced respiratory distress beginning around 1919 hours on June 3, 2025. Corrections staff called PENCOM at 1935 hours, requesting medics to respond to the jail. CPR was initiated at 1956 hours, and the decedent was transported by medics to Olympic Medical Center, where he was later pronounced deceased.

The responding investigator coordinated with the county coroner at Olympic Medical Center, where the decedent's body was photographed, sealed, and taken into the coroner's custody. The decedent remained dressed in jail-issued clothing and footwear, which were secured with the body.

Investigators reviewed facility surveillance video showing the decedent exhibiting visible respiratory distress prior to collapsing. The video depicted the decedent pacing, appearing flushed and diaphoretic, and removing the upper portion of his jumpsuit before pressing the emergency call button for his inhaler. Jail staff responded promptly, and medical personnel were contacted as the decedent's condition worsened.

Statements from responding corrections staff and the jail nurse indicated that the decedent's oxygen levels dropped significantly despite the use of an inhaler and medical monitoring, leading to the decision to summon EMS. The nurse confirmed that the decedent had been recently evaluated at Olympic Medical Center on June 1, 2025, for similar respiratory complaints and had been prescribed inhalers and related medications.

As part of the contraband investigation, drug screening tests were conducted on the decedent's cellmate and pod mate. Results showed that a cellmate tested negative for controlled substances, while another cellmate tested positive for buprenorphine and fentanyl. A search was conducted of A-tank, and no drugs or contraband were found. All documentation, including medical records, surveillance footage, and drug test results, was submitted to the Sequim Police Department records division for review.

Cause of Death

The final Coroner's report and Pathologist autopsy report conducted by the King County Medical Examiner's Office found the cause of death as saddle pulmonary thromboembolus due to deep venous thrombosis of the right lower extremity. The decedent's risk factors for deep venous thrombosis of the lower extremities were unknown.

Postmortem urine screened positive for methamphetamine and amphetamine.

A saddle pulmonary thromboembolism (PE) resulting from a deep vein thrombosis (DVT) of the lower right extremity is a life-threatening condition where a large blood clot from the right leg travels to the lungs, lodges at the point where the pulmonary artery splits, and blocks blood flow to both lungs. This blockage, originating in the leg's deep veins, can cause severe symptoms like sudden shortness of breath, chest pain, and rapid heart rate, requiring immediate medical treatment

Committee Review & Discussion

Each committee member was provided with OneDrive access containing the following information for review:

- Inmate's complete booking file
- Photo and video evidence
- Inmate's medical records
- Corrections Deputies' incident reports
- Corrections Deputy welfare check logs relating to the incident
- Corrections Facility 24-hour log relating to the incident
- Investigation and evidence report (Sequim Police 2025-05523)
- Coroner's reports, autopsy results, and toxicology results.
- Relevant CCSO Correction policies

The potential factors reviewed include:

A. Structural
    a. Risk factors in design or environment
    b. Broken or altered fixtures or furnishings
    c. Security measures compromised or circumvented
    d. Lighting
    e. Camera

B. Clinical
    a. Relevant decedent health issues/history
    b. Interactions with jail health services
    c. Relevant root cause analysis and/or corrective action sought

C. Operational
    a. Supervision (welfare checks/observation)
    b. Classification/Housing
    c. Staffing levels
    d. Training recommendations
    e. Phone call and visitation review
    f. Known self-harm
    g. Lifesaving measures taken

Committee Findings

The Committee determined that the response and management of this unfortunate event which led to the loss of a life was conducted in a professional and appropriate manner. Every available tool and resource was utilized in the attempt to save this individual's life.

Structural

The incident took place in the dayroom of A-tank, a four-person cell at the Clallam County Correction Facility. The unit had adequate lighting which was not covered. All lighting was operational during the emergency.

The camera in the A-tank dayroom recorded the lifesaving efforts and medical response.

All other fixtures, including the emergency call buttons, were operational, as proven by their use in the event.

Clinical

The committee reviewed all medical documentation provided for the Unexpected Fatality Review (UFR) and found that policies were followed, clinical notes were well documented, and appropriate treatment was provided.

The committee reviewed the death of the decedent while in custody. The reviewing doctor determined the cause of death was a saddle pulmonary embolism, a rare condition that is almost always fatal without immediate ICU-level hospital care. The decedent's main risk factors were smoking and methamphetamine use. The condition developed in the community and was not related to being in jail.

Jail medical staff appropriately recognized a medical emergency on June 1 and sent the decedent to the OMC emergency department. The reviewing doctor stated the main error occurred at the hospital, where the decedent was misdiagnosed with COPD. The hospital's EKG was abnormal, showing Q-wave patterns consistent with cardiac strain that should have raised concern for a pulmonary embolism. The decedent's sudden shortness of breath, low oxygen, low blood pressure, and high heart rate were also inconsistent with COPD and pointed to a pulmonary embolism.

Despite these findings, the decedent was discharged back to jail and treated with albuterol, which can worsen pulmonary embolism. The doctor noted that if blood thinners had been started, the clot might have reduced, but without them, it continued to grow, leading to death.

In summary, jail staff acted appropriately in recognizing the emergency, and the critical error occurred at the hospital level due to misdiagnosis and missed signs of pulmonary embolism.

Operational
At the time of the incident, the shift had the required staffing level for operation. It was determined that all responding Corrections staff acted within policy. Uniformed Corrections Deputies immediately requested assistance. The reviewing doctor stated that the response time was reasonable and that even if staff had responded twenty minutes earlier, it would not have changed the outcome, as the decedent was already severely hypoxic and likely to die at that point.

Committee Recommendation

As with all reviews of critical incidents in our facility, recommendations, although unrelated to the outcome of this incident, were made in effort to strengthen measures to maintain a safe, secure, and constitutional facility.

- Per the reviewing doctor, jail medical staff should remain alert to "anchoring", a cognitive bias in which clinicians place too much weight on an initial diagnosis and fail to adjust when new or conflicting information appears. Staff should carefully review all hospital discharge summaries and diagnoses, and if findings or observations contradict the hospital's conclusions, they should promptly return the patient to the emergency department for reevaluation.